Supreme Court, U.S.
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No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

BLUE CROSS AND BLUE SHIELD ASSOCIATION,
Petitioner,

v.

REBECCA T. HUBBARD and JIM HUBBARD,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

A. Whether a state law fraud in the inducement claim against an alleged agent of a benefit plan insurer "relates to" an employee benefit plan and is preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, *et seq.*, as amended ("ERISA").

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On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

Blue Cross and Blue Shield Association ("Association")[1] respectfully petitions this Court for a writ of certiorari to review the final judgment of the United States Court of Appeals for the Fifth Circuit in this case.

Plaintiffs allege that the Association conducted false advertising for and on behalf of the insurer of an employee benefit plan and that these advertisements induced

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[1] All parties to the proceeding below are listed in the caption to this petition. The Association has no parents, subsidiaries, or affiliates that have issued shares or debt securities to the public.

plaintiffs into participating in the insurance policy funding the benefit plan. Plaintiffs' claim is based entirely on state law and particularly, a state deceptive trade practices statute. The Fifth Circuit incorrectly held that plaintiffs' state law fraud in the inducement claim against the Association, an alleged agent of the benefit plan insurer, was not preempted by ERISA because the Fifth Circuit concluded that the Association was not an "ERISA entity".

This Court should grant certiorari and summarily reverse the Fifth Circuit decision because it conflicts with this Court's decisions in *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41 (1987) and *Ingersoll-Rand Company v. McClendon*, 498 U.S. 133 (1990). This Court has made it clear that the statutory criterion for preemption is whether a state law "relates to" an employee benefit plan, not whether the defendant is an "ERISA entity". To the extent the Fifth Circuit has added an additional criterion to the preemption analysis, the decision below is in direct conflict with *Pilot Life* and *Ingersoll-Rand*.

In the alternative, this Court should grant certiorari to review the Fifth Circuit decision because the decision conflicts with decisions by the Eleventh, Ninth, Eighth, and Seventh Circuits and is also part of an ongoing conflict among the federal circuit courts and between the federal circuit courts and at least one state court of last resort with respect to whether state law fraud in the inducement claims are preempted by ERISA. This longstanding conflict has caused substantial confusion among the lower federal and state courts regarding the extent of ERISA preemption. Resolution of this conflict is necessary to carry out Congress' intent that employee benefit plans be subject to uniform federal regulation; to prevent

the written terms of employee benefit plans from being subject to *de facto* oral modification; and to prevent benefit plan participants from bypassing ERISA's exclusive civil enforcement scheme.

OPINIONS AND ORDERS BELOW

The opinion of the United States Court of Appeals for the Fifth Circuit, filed on January 12, 1995, is reported at 42 F.3d 942 and is reproduced at Appendix ("App.") 1-11. Relevant decisions of the United States District Court for the Southern District of Texas are reproduced at App. 12-21.

JURISDICTION

This action was originally filed in state court. It was removed to the United States District Court for the Southern District of Texas on April 27, 1992. The district court had jurisdiction over this action pursuant to ERISA, §502(e)(1), 29 U.S.C. §1132(e)(1),[2] and general federal question jurisdiction under 28 U.S.C. §1331. On October 8, 1992, the district court granted summary

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[2] ERISA, section 502(e)(1), 29 U.S.C. §1132(e)(1), provides as follows:

> Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

judgment to the Association, holding that plaintiffs' state law claims are preempted by ERISA. Plaintiffs appealed to the Fifth Circuit. The Fifth Circuit affirmed the summary judgment in part and reversed and remanded the summary judgment in part on January 12, 1995. This Petition is being filed within the 90-day period following entry of that order pursuant to Sup. Ct. R. 13.1 and 13.3. This Court has jurisdiction to review cases in the federal courts of appeals after rendition of a judgment pursuant to 28 U.S.C. § 1254.

STATUTES INVOLVED

This case involves sections 502(a), and 514(a) of ERISA, 29 U.S.C. §§ 1132(a), 1144(a).[3]

STATEMENT OF THE CASE

A. Statement of Facts

For purposes of the summary judgment motion at issue herein, the undisputed facts are as follows:

Rebecca Hubbard was a participant in an employee welfare benefit plan established and maintained by her employer. The plan provided, among other things, medical benefits to participants and their beneficiaries in accordance with the written terms of the plan. The benefit plan was funded, at least in part, by a policy of insurance issued by Blue Cross and Blue Shield of Texas, Inc. ("Blue Cross of Texas").

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[3] The text of these statutes is set out verbatim at App. 29 and App. 30, respectively.

Plaintiff contracted cancer while she was a participant under the benefit plan. She applied for plan benefits to pay for certain requested cancer treatments. Blue Cross of Texas denied plaintiff's benefit claim and a lawsuit followed.[4]

After Blue Cross of Texas denied plaintiffs' claim for benefits, plaintiff filed this action. Plaintiff brought state law fraudulent inducement claims against the Association, alleging: (1) that the Association wrongfully concealed certain policy interpretation guidelines which were followed by Blue Cross of Texas in denying plaintiffs' claim; and (2) that the Association produced and disseminated advertisements for and on behalf of Blue Cross of Texas which depicted Blue Cross of Texas as a "forthright" company, thereby fraudulently inducing plaintiff into participating in the benefit plan funded by the Blue Cross of Texas policy.[5] Plaintiffs also sued plaintiffs' physician for medical malpractice. This state law claim was remanded to the state court and is not at issue here.

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[4] The lawsuit with Blue Cross of Texas was ultimately settled for $12,500. App. 10.

[5] The relationship between the Association and Blue Cross of Texas was described by the Fifth Circuit as follows:

> The insurer, Blue Cross of Texas, and the defendant-appellee, Blue Cross and Blue Shield Association, are separate legal entities despite their similar names. The Association is incorporated in Illinois and is the trademark corporation that administers the licensing of the 'Blue Cross' and 'Blue Shield' registered trademarks. The Association did not issue the Hubbards' insurance policy and did not have the right or power to make coverage decisions under that policy.

App. 10.

B. Decisions of the Courts Below

Shortly after this matter was removed to federal court, plaintiff filed a motion to remand. On July 28, 1992, the district court held that plaintiffs' state law claims against the Association "relate[d] to" the benefit plan and were preempted by ERISA. In deciding the preemption issue, the district court correctly focused on the nature of plaintiffs' claims. The court concluded that plaintiffs' state law allegations were based on the denial of coverage under the plan and that alleging that a third party rather than the plan itself caused the denial "does not change the nature of the claim". App. 14. The court further concluded that plaintiffs' damage claims were, in essence, "those expenses that would have been covered by the plan but for the alleged conduct of" the Association. *Id.* The district court denied plaintiffs' motion to remand.[6]

The Association filed a motion for summary judgment. On October 8, 1992, the district court granted the motion. The district court reiterated its conclusion that the essence of plaintiffs' state law claims was that benefits were improperly denied under the plan and that resolution of their claims would have the effect of orally modifying the terms of the plan. Noting that plaintiffs' claims could not exist but for the ERISA plan and that plaintiffs' claims related to their rights to benefits under the plan, the court held that plaintiffs' claims addressed areas of exclusive federal concern, affected the relationship among the traditional ERISA entities, and that they were preempted. App. 19-20.

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[6] On September 8, 1992, the district court also denied plaintiffs' request for a rehearing on the motion to remand. App. 15-16.

On appeal, the Fifth Circuit affirmed in part and reversed and remanded in part the summary judgment. The Fifth Circuit *correctly* held that plaintiffs' claim regarding the alleged policy interpretation guidelines *was preempted* even though the claim was against a third party rather than the plan insurer. App. 6. The appellate court agreed with the district court that "the essence of Hubbard's claim is that her benefits under the plan were improperly denied" and that resolution of plaintiffs' state law claim was "intricately bound up with the interpretation and administration of an ERISA plan". *Id.*

The Fifth Circuit *incorrectly* held that plaintiffs' advertising claim was *not preempted* by ERISA. The court relied on its previous erroneous decision in *Perkins v. Time Insurance Company*, 898 F.2d 470 (5th Cir. 1990) and held that although such a claim against the plan insurer *is* preempted by ERISA, the same claim against the insurer's agent *is not* preempted because "the claim merely affects relations between an ERISA entity and an outside party, rather than between two ERISA entities". App. 8. The Association seeks review of this latter holding.[7]

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[7] The Fifth Circuit also incorrectly relied on its previous opinion in *Memorial Hospital System v. Northbrook Life Ins. Co.*, 904 F.2d 236 (5th Cir. 1990) which held that a claim for benefits by a *plaintiff* that was not a participant or beneficiary in an employee benefit plan was not preempted by ERISA. Whatever the merit of the Fifth Circuit's decision in *Memorial Hospital*, it is unclear how that case applies to the case at hand. Unlike the plaintiff in *Memorial Hospital*, at least for purposes of this petition, there is no dispute that the plaintiffs in the instant case are ERISA plan participants and therefore specifically authorized to bring actions under ERISA's civil enforce-

(continued...)

The Fifth Circuit issued its mandate and remanded the case to the district court on February 7, 1995. On February 10, 1995, the district court remanded the matter to the state court.

REASONS FOR GRANTING THE WRIT

A. Congress Enacted ERISA to Establish Uniform Regulation of Employee Benefit Plans By Giving Preeminence to Federal Law.[8]

In order to establish uniformity in the regulation of employee benefit plans, Congress enacted ERISA, §514(a), 29 U.S.C. §1144(a), which broadly preempts all state laws that "relate to" employee benefit plans.[9] Congress also gave an expansive definition to state law, including

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[7] (...continued)
ment section. *See* ERISA, §502(a), 29 U.S.C. §1132(a) (providing ERISA plan participants and beneficiaries with various avenues of relief for alleged ERISA and benefit plan violations). Moreover, federal district courts are expressly granted jurisdiction over such claims by participants and beneficiaries. ERISA, §502(e)(1), 29 U.S.C. §1132(e)(1) (limiting federal court jurisdiction to claims brought under ERISA by "the Secretary, or by a participant, beneficiary, or fiduciary"). There is no provision in the statute limiting this jurisdiction to claims made *against* non-ERISA *defendants*. Obviously, the decision in *Memorial Hospital* has no bearing on the case at hand.

[8] There is no dispute that the benefit plan under which plaintiff sought benefits is an employee benefit plan governed by ERISA.

[9] There are only limited exceptions to ERISA preemption of state law. By virtue of the Saving Clause, state laws which regulate insurance, banking, and securities are excepted from preemption. ERISA, §514(b)(2)(A), 29 U.S.C. §1144(b)(2)(A). The Fifth Circuit did not address whether plaintiffs' fraud in the inducement claim was covered by any of these exceptions.

"decisions", "laws", "rules", and "regulations" within the preemptive reach of ERISA. ERISA, §514(c)(1), 29 U.S.C. §1144(c)(1). This was a critical part of Congress' effort to ensure the total "displacement of State action in the field of private employee benefit programs". *See* 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits).

B. Consistent with the Intent of Congress, this Court Has Continually Given a Broad Interpretation and Application to ERISA's Preemption Clause.

This Court has repeatedly acknowledged the expansive nature of preemption of state law under ERISA, the exclusivity of ERISA's civil enforcement scheme, and the focus of Congress on the uniform regulation of employee benefit plans. *See, e.g., District of Columbia v. The Greater Washington Board of Trade*, 506 U.S. ___, 121 L.Ed.2d 513, 113 S.Ct. 580 (1992) (state law requiring employers to provide same level of health insurance coverage for employees eligible for worker's compensation is preempted by ERISA); *Ingersoll-Rand Company v. McClendon*, 498 U.S. 133 (1990) (state law wrongful discharge claim is preempted by ERISA); *FMC Corporation v. Holliday*, 498 U.S. 52 (1990) (state laws prohibiting subrogation by self-funded benefit plans are preempted by ERISA); *Mackey v. Lanier Collections Agency & Service, Inc.*, 486 U.S. 825 (1988) (state law specifically exempting ERISA plans from garnishment procedures is preempted by ERISA); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987) (state law tort and contract claims are preempted by ERISA); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (state law breach of contract, bad faith, and fraud in the inducement claims are preempted by ERISA); *Shaw v. Delta Air Lines, Inc.*, 463

U.S. 85 (1983) (state law prohibiting discrimination in employee benefit plans is preempted by ERISA).

This Court has stated on several occasions that the preemption provision of ERISA is extremely broad. *See, e.g., Pilot Life*, 481 U.S. 45-46 ("the express pre-emption provisions of ERISA are deliberately expansive"); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983) ("the breadth of [29 U.S.C. §1144(a)'s] pre-emptive reach is apparent . . . ."). Furthermore, because Congress used the phrase "relate to" in its broad sense, this Court has "emphasized that the pre-emption clause is not limited to 'state laws specifically designed to affect employee benefit plans.' " *Pilot Life*, 481 U.S. at 47-48. *Accord, Shaw*, 463 U.S. at 98 (preemption clause should not "be interpreted to pre-empt only state laws dealing with the subject matters covered by ERISA—reporting, disclosure, fiduciary responsibility, and the like").

Congress used "deliberately expansive" language in ERISA's preemption clause that was "designed to 'establish pension plan regulation as exclusively a federal concern' ". *Pilot Life*, 481 U.S. at 46 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981)). Nowhere did Congress more clearly demonstrate its desire for uniform regulation of employee benefit plans than in its enactment of ERISA's detailed civil enforcement scheme.[10] This civil enforcement scheme "is one of the essential tools for accomplishing the stated purposes of ERISA". *Pilot Life*, 481 U.S. at 52. In order to promote uniform regulation of employee benefit plans, states are prohibited from supplementing or detracting from these reme-

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[10] *See* ERISA, §502, 29 U.S.C. §1132.

dies. *See, e.g., Pilot Life, supra*; *Metropolitan Life v. Taylor, supra*; *Ingersoll-Rand v. McClendon, supra.*

C. This Court's Decisions in *Pilot Life v. Dedeaux* and *Ingersoll-Rand v. McClendon* Illustrate the Breadth of ERISA's Preemption of State Law, Particularly as it Relates to State Law Fraud in the Inducement Claims.

In *Pilot Life*, the plaintiff participated in an employee disability benefits plan that was funded by a policy of insurance for which the plaintiff paid half of the premiums. In 1975, Dedeaux sought and was awarded benefits under the disability plan. During the next five years, Pilot Life terminated and reinstated Dedeaux's disability benefits several times. In 1980, Dedeaux filed suit under state law alleging tortious breach of contract, breach of fiduciary duties, and fraud in the inducement under state law. 481 U.S. at 43. Like the plaintiffs in the case at hand, Dedeaux did not assert any causes of action under ERISA. *Id.*

Dedeaux's complaint reveals that the factual basis for his fraud in the inducement claim was virtually identical to the fraud claim made by the plaintiffs in the case at hand.[11] Dedeaux alleged that the defendants made certain written and oral promises to him in the sales presentations regarding the disability insurance policy. App. 27-28. Dedeaux alleged that the alleged promises were made for the purpose of inducing Dedeaux to enroll in

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[11] Plaintiff's complaint in the *Pilot Life* case was included in the Joint Appendix filed with this Court. A copy of the complaint, printed from the Lexis United States Supreme Court Brief database, is appended hereto beginning at App. 22-28.

the plan and to pay premiums for the insurance coverage. *Id.*

The federal district court granted summary judgment to Pilot Life, concluding that all of Dedeaux's state law claims, including the fraud in the inducement claim, were preempted by ERISA. The Fifth Circuit reversed, holding that the state law causes of action were not preempted.

This Court granted certiorari to resolve the issue of "whether [ERISA] pre-empts state common law tort and contract actions asserting improper processing of a claim for benefits under an insured employee benefit plan". 481 U.S. at 43. This Court noted that Dedeaux had relied on three separate state law causes of action, including a claim for fraud in the inducement. *Id.* at 43-44. Although most of the Court's discussion concerned whether Dedeaux's "tortious breach of contract" claim was "saved" from preemption as a law that regulated insurance, this Court made it clear that *all* of Dedeaux's state common law claims, including his claim for fraud in the inducement, were preempted by ERISA:

> There is no dispute that the common law causes of action asserted in Dedeaux's complaint 'relate to' an employee benefit plan and therefore fall under ERISA's express preemption clause . . . The common law causes of action raised in Dedeaux's complaint, *each based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly meet the criteria for pre-emption under [ERISA] §514(a).*

Id. at 47-48. Thus, this Court held that Dedeaux's fraud in the inducement claim, which was based on misrepresentations that occurred before Dedeaux purchased cov-

erage under the insurance policy, "relate[d] to" an employee benefit plan and was preempted by ERISA.

This Court further bolstered its preemption holding by stating that the most important consideration in determining whether a state law will be preempted is Congress' clear intent that the civil enforcement scheme of ERISA be exclusive. 481 U.S. at 51-57. ERISA provides a comprehensive, and therefore exclusive, mechanism for employees to enforce their rights, bring claims, and monitor their fiduciaries, as well as specific remedies for parties that prevail. *Pilot Life*, 481 U.S. at 52-56. The comprehensive enforcement schemes set out in ERISA, §502(a), 29 U.S.C. §1132(a), "represent a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Pilot Life*, 481 U.S. at 54. *Accord, Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987) (suit by beneficiary to recover benefits under an employee benefit plan/insurance policy "falls directly under [29 U.S.C. §1132(a)(1)] of ERISA, which provides an exclusive federal cause of action for resolution of such disputes").

This Court reaffirmed the breadth of ERISA preemption and the exclusive nature of ERISA's civil remedy scheme in *Ingersoll-Rand v. McClendon, supra*. The plaintiff in *Ingersoll-Rand* brought a state law action against his employer alleging that he was terminated from his employment in order to prevent the vesting of retirement benefits. This Court held that the plaintiff's state law cause of action was both expressly preempted by ERISA's preemption clause and implicitly preempted because the state law remedy conflicted with a remedy provided by ERISA.

In holding that the plaintiff's state law claim was expressly preempted by ERISA, this Court reiterated the themes discussed in *Pilot Life*. This Court again noted how ERISA's preemption clause is "conspicuous for its breadth" and that its "deliberately expansive language" was designed to establish employee benefit plan regulation "as exclusively a federal concern". 498 U.S. at 138. This Court also reaffirmed the principle that in using the phrase "relate to" in ERISA's preemption clause, "Congress used those words in their broad sense, rejecting more limited pre-emption language that would have made the clause 'applicable only to state laws relating to the specific subjects covered by ERISA' ". *Id.* Because of the breadth of ERISA's preemption clause, this Court stated that "[p]re-emption is also not precluded simply because a state law is consistent with ERISA's substantive requirements". *Id.* at 139.

In applying these principles to the state law claim brought by the plaintiff, a key factor in finding preemption was that the success of plaintiff's state law claim hinged on the existence of an employee benefit plan. *Id.* at 140. Under this analysis, this Court had "no difficulty" in holding that the state law claim was *expressly* preempted by ERISA. The Court found this result to be completely consistent with the purposes and intent of Congress in establishing uniformity in the regulation of employee benefit plans by making federal law preeminent:

> Section 514(a) was intended to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government. Otherwise, the inefficiencies created could work to the detriment of plan

> beneficiaries . . . Allowing state based actions like the one at issue here would subject plans and plan sponsors to burdens not unlike those that Congress sought to foreclose through §514(a). Particularly disruptive is the potential for conflict in substantive law. *It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement.*

Id. at 142.

This Court also found the plaintiff's state law claim to be *implicitly* preempted by federal law, even absent ERISA's express preemption provision. The Court noted that ERISA provided plaintiff with a specific cause of action, albeit one that did not afford plaintiff with all of the remedial options available under state law, and that any state law cause of action was in direct conflict with ERISA's civil enforcement scheme.[12] Moreover, the plaintiff's attempt to characterize his claim as one for "damages" rather than for "benefits" did not alter this Court's preemption analysis: "it is no answer to a pre-emption argument that a particular plaintiff is not seeking recovery of [plan] benefits". *Id.* at 145.

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[12] This Court noted that the plaintiff could bring an action under ERISA's general equitable relief provision, §502(a)(3), 29 U.S.C. §1132(a)(3). This section allows for the award of equitable relief only (such as injunction, mandamus, and restitution) but does not provide for the recovery of compensatory or punitive damages as might otherwise be available under state law. *Mertens v. Hewitt Associates*, 508 U.S. ___, 124 L.Ed.2d 161, 113 S.Ct. 2063 (1993).

In summary, this Court has consistently held that the breadth of ERISA's preemption clause and the exclusive nature of ERISA's civil enforcement scheme dictate that all state laws that "relate to" employee benefit plans, including claims of fraud in the inducement, are preempted. To achieve the uniformity of regulation intended by Congress, employee benefit plans are governed exclusively by federal law.

D. The Decision Below Should be Summarily Reversed Because it Directly Conflicts with this Court's Decisions in *Pilot Life v. Dedeaux* and *Ingersoll-Rand v. McClendon*.

There can be no doubt that, however plaintiffs attempt to characterize their state law claim in order to avoid preemption, it clearly involves and certainly arose out of the processing of plaintiff's claim for benefits by Blue Cross of Texas. In their state law fraud in the inducement claim, plaintiffs allege that the Association falsely advertised that Blue Cross of Texas was a forthright company in paying benefits under the plan. Clearly, this state law claim is inextricably intertwined with the processing of plaintiffs' claim for benefits and administration of the benefit plan. Accordingly, under the analysis mandated by this Court in *Pilot Life*, plaintiffs' state law claim "relates to" the benefit plan and is preempted by ERISA.

The decision below conflicts with this Court's holding in *Pilot Life*. In holding that plaintiffs' advertising fraud claim was not preempted, the Fifth Circuit rendered the "relates to" test irrelevant even though this test is expressly dictated by the ERISA statute and even though this Court has held that the test is to be broadly applied.

The Fifth Circuit instead fundamentally modified the preemption analysis by adding an additional non-statutory criterion to the preemption equation: whether the defendant is an "ERISA entity". App. 7-8. The Fifth Circuit cited no authority from the statute or from decisions of this Court to justify application of this additional preemption criterion. *Id.* Moreover, the appellate court inexplicably applied this criterion to the Association notwithstanding the fact that the plaintiffs alleged that the Association produced the advertisements as an agent *for* an admitted "ERISA entity" (i.e. the plan insurer). App. 4.

Pilot Life makes it clear that the *sole* factor used to determine preemption of state law is whether state law "relates to" an employee benefit plan. Indeed, this is the very factor selected by Congress: "[ERISA] shall supersede *any and all* State laws insofar as they may now or hereafter *relate to* any employee benefit plan". ERISA, §514(a), 29 U.S.C. §1144(a) (emphasis added).

Pilot Life also makes it clear that state law claims for fraud in the inducement which are based on pre-plan representations that allegedly induce the plaintiff into participating in the plan are preempted because they "relate to" the benefit plan. The very basis for plaintiffs' state law cause of action is the allegation that the Association represented that Blue Cross of Texas was a forthright company in processing benefit claims. This state law claim is inextricably intertwined with the processing of plan benefits and administration of the employee benefit plan. The state law claim therefore "relates to" the plan and is preempted. That portion of the Fifth Circuit opinion which holds that plaintiffs' state law claim against the Association is not preempted is inconsistent with *Pilot Life*.

The Fifth Circuit's holding also conflicts with this Court's decision in *Ingersoll-Rand v. McClendon*. In *Ingersoll-Rand*, this Court held that a state law claim "relates to" a benefit plan and is expressly preempted by ERISA where the existence of a benefit plan is one of the bases for the state law claim. In the case at hand, the existence of a benefit plan is a necessary element and a basis for plaintiffs' state law claim. Indeed, plaintiffs' entire claim arose only after Blue Cross of Texas denied their claim for plan benefits. Without an existing benefit plan or if plaintiffs had opted not to participate in the Blue Cross of Texas policy, there would be no cause of action. The Fifth Circuit presumably agreed that the existence of a benefit plan was a necessary element of plaintiffs' state law claim because it implied that such a claim against the insurer would be preempted. There is, however, no explanation as to why plaintiffs' claim was suddenly not preempted simply because plaintiffs alleged that the Association did the advertising for and on behalf of the insurer. Such a holding conflicts with this Court's decision in *Ingersoll-Rand* and should be summarily reversed.

E. The Decision Below Conflicts with Several Decisions by other Federal Circuit Courts and is the Latest Decision in a Longstanding Conflict Among the Federal Circuit Courts and Between the Federal Circuit Courts and a State Court of Last Resort Concerning Preemption of State Law Fraud in the Inducement Claims under ERISA.

The Fifth Circuit held that a fraud in the inducement claim which arose out of advertising by the Association allegedly on behalf of the plan insurer and which arose as a result of the insurer's decision to deny plaintiffs'

claim for plan benefits, was not preempted by ERISA. The appellate court found its previous decision in *Perkins v. Time Ins. Co., supra*, controlling. In *Perkins*, the plaintiff alleged that an insurance agent had made certain representations about coverage under a prospective group insurance policy which induced the plaintiff to obtain coverage under the policy. The representations turned out to be inconsistent with the terms of the policy. After plaintiff's claim for plan benefits was denied, the plaintiff sued the insurer and the insurer's agent claiming state law fraud in the inducement. The Fifth Circuit held that while the state law claim against the insurer was preempted, the claim against the insurer's agent was not preempted. In the decision below, the Fifth Circuit likened the role of the Association to that of the agent in *Perkins* and likewise held that the plaintiffs' state law fraud in the inducement claim against the Association (i.e. the "agent") was not preempted. App. 7-8.

The decision below, and its predecessor *Perkins*, are in direct conflict with decisions by the Eleventh, Ninth, Eighth, and Seventh Circuits which have held that state law claims based on pre-plan representations by insurers and/or their alleged agents regarding processing of benefits under an ERISA plan are preempted by ERISA:

- In *Farlow v. Union Central Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989), the plaintiff alleged that the insurer's agent made certain representations about coverage under a group policy and that the plaintiffs' employer relied on those representations in deciding to change group insurers for its employees. After plaintiffs' claim for plan benefits was later denied by the insurer, the plaintiffs sued the insurer and the insurer's agent based on state law

fraud in the inducement. Correctly looking to the nature of the plaintiff's claim rather than the identity of the defendant, the Eleventh Circuit held that the agent's alleged conduct was "intertwined with the refusal to pay benefits". *Id.* at 794. Relying on this Court's decision in *Pilot Life*, the Eleventh Circuit held that the fraud in the inducement claims against the agent and the insurer were preempted.

- In *Cantrell v. Great Republic Ins. Co.*, 873 F.2d 1249 (9th Cir. 1989), the plaintiff alleged that she was interviewed by the insurer's agent regarding her medical history prior to her participation in the benefit plan insurance policy. After plaintiff's benefit claims were later denied and her coverage rescinded by the insurer, plaintiff filed suit under state law. Among other things, plaintiff alleged that the agent made certain representations regarding coverage under the benefit plan. The Ninth Circuit noted that this Court held that the state law claims in *Pilot Life* (including the fraud in the inducement claim) were preempted. The Ninth Circuit held that Cantrell's attempts to avoid characterizing her action as one for alleged improper processing of her claims for benefits were futile and that Cantrell's state law claims were indistinguishable from the state law claims found preempted in *Pilot Life*. Accordingly, the Ninth Circuit held that plaintiff's state law claims were preempted.
- In *Consolidated Beef Industries, Inc. v. New York Life Ins. Co.*, 949 F.2d 960 (8th Cir. 1991) *cert. den.*, 112 S.Ct. 1670 (1992), an employer purchased a turnkey §401(k) program for its employees. After problems developed with the program, the employer sued, alleging state law claims based on alleged misrepresentations by defendant's agent in the sale of the program. Although the Eighth Circuit held that the employer's allegations were not supported

by the record, the Court relied on *Farlow*, *supra* to hold that the employer's claims regarding pre-plan representations by the agent "relate[d] to" the benefit plan and were preempted. The Court also held that the state law claims were preempted regardless of whether the defendant was a fiduciary of the benefit plan and regardless of whether the plaintiff had a remedy under ERISA.

- In *Anderson v. Humana, Inc.*, 24 F.3d 889 (7th Cir. 1994), the plaintiff elected to participate in a health maintenance program sponsored by her employer. Plaintiff later sued, alleging that the HMO committed fraud and engaged in deceptive trade practices. Specifically, plaintiff alleged that HMO sales literature failed to disclose certain financial relationships and incentives to prospective participants and that she was thereby fraudulently induced to participate in the HMO program. The Seventh Circuit held that plaintiff's state law fraud in the inducement claim "lies comfortably within the zone of exclusive federal control" and was therefore preempted by ERISA. 24 F.3d at 891. *See also Pohl v. National Benefits Consultant, Inc.*, 956 F.2d 126 (7th Cir. 1992) (misrepresentation claim against nonfiduciary claims administrator is preempted regardless of whether there is a valid claim under ERISA's civil enforcement scheme).

The above decisions are in stark contrast to the decision below and its predecessor, *Perkins*. The above decisions are correctly based on an analysis of the *nature of the plaintiff's claim* and whether it arises out of and/or is related to the processing of a claim for plan benefits. These decisions are consistent with the preemption analysis employed by this Court in *Pilot Life* and *Ingersoll-Rand*. On the other hand, the Fifth Circuit decisions below and in *Perkins* ignore the nature of the plaintiffs'

claim and erroneously focus on the identity of the defendant. App. 7-8; *Perkins*, 898 F.2d at 473.

The conflict in the *results* reached by the above courts is further exacerbated by the conflict in *reasoning* between the Fifth Circuit decision below and in *Perkins* and the decisions by several other federal appellate and state courts. Indeed, the rationales applied by the various courts in determining whether state law fraud in the inducement claims are preempted include every possible theory and variation thereof:

- In *Perry v. P*I*E Nationwide, Inc.*, 872 F.2d 157 (6th Cir. 1989), several participants in an employee benefit plan alleged that they were induced to participate in the plan by their employer's misrepresentations. The Sixth Circuit held that their state law fraud in the inducement claim was not preempted because the representations occurred prior to their participation in the plan and because ERISA apparently provided no remedy for the alleged wrong. The latter portion of this holding is itself in conflict not only with later Sixth Circuit precedent, but also with holdings in other circuits. *See, e.g., Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272 (6th Cir. 1991) *cert. dismissed* 113 S.Ct. 2 (1992) (plaintiff's state law claims are preempted even though the plaintiff had no standing to bring any action under ERISA's civil remedy provision); *Corcoran v. United Healthcare, supra*; *Raymond v. Mobil Oil Corporation*, 983 F.2d 1528, 1538 (10th Cir. 1993) *cert. den.* ___ U.S. ___, 114 S.Ct. 1070, 127 L.Ed.2d 388 (1994) ("the fact that a state law claim may be preempted does not necessarily mandate that there be an ERISA remedy"); *Hospice of Metro Denver v. Group Health Ins.*, 944 F.2d 752, 755 (10th Cir. 1991) ("preemption normally is not dependent upon the availability of

ERISA remedies"); *Lister v. Stark*, 890 F.2d 941, 946 (7th Cir. 1989) *cert. den.* 498 U.S. 1011 (1990) ("the availability of a federal remedy is not a prerequisite for federal preemption").

- In *HealthAmerica v. Menton*, 551 So.2d 235 (Ala. 1989) *cert. den.*, 493 U.S. 1093 (1990), the plaintiff alleged that he relied on certain misrepresentations by a representative of a health maintenance organization in deciding to switch his employment-related health coverage. After the HMO denied his claim for plan benefits, plaintiff sued claiming state law fraud in the inducement. The Alabama Supreme Court held that the plaintiff's claim was not preempted by ERISA. It reasoned that plaintiff's claim did not involve allegations of improper processing of a claim for benefits and rejected application of *Pilot Life*. The Alabama Supreme Court acknowledged that federal court decisions are "disparate" on the issue of preemption of fraud in the inducement claims but rejected the conflicting Eleventh Circuit holding in *Farlow*, *supra* and instead relied on the Sixth Circuit decision in *Perry*, *supra*. 551 So.2d at 244. The Alabama Supreme Court recently reaffirmed this holding in *Ingram v. American Chambers Life Ins. Co.*, 643 So.2d 575 (Ala. 1994), again rejecting application of *Pilot Life* and noting that the federal circuit courts "do not agree about whether ERISA preempts a state law claim of fraud in the inducement". *Id.* at 577. The Alabama Supreme Court also implied that this Court's decision to deny certiorari in *HealthAmerica* constituted tacit approval of its decision in that case. *Id.*
- Although not addressing the preemption issue directly, the Tenth Circuit in *Uselton v. Commercial Lovelace Motor Freight, Inc.*, 940 F.2d 564 (10th Cir. 1991) *cert. den.* 112 S.Ct. 589, relied on the Sixth Circuit decision in *Perry* and the Fifth Circuit

decision in *Perkins* and stated in *dicta* that state law claims for fraud in the inducement are not preempted by ERISA because ERISA does not provide a remedy for the alleged misconduct and because such claims do not "relate to" the benefit plan.

In summary, the decision below, and the decisions in *Perkins*, *Perry*, *HealthAmerica*, *Ingram*, and *Uselton*, although in agreement that fraud in the inducement claims are not preempted by ERISA, are in sharp disagreement as to the rationale for such a conclusion. In the Fifth Circuit, preemption apparently hinges on the identity of the defendant. In the Sixth and Tenth Circuits, preemption of fraud in the inducement claims may hinge on whether there is an alternative remedy under ERISA, although even those circuits are not consistent on that point. In Alabama, fraud in the inducement claims are not deemed to "relate to" the benefit plan at all, even though the Eleventh Circuit says otherwise. All of these decisions are in conflict with decisions in the Eleventh, Ninth, Eighth, and Seventh Circuits which correctly hold that the nature of the claim governs preemption and that pre-plan misrepresentations by insurers and/or their alleged agents "relate to" the plan and are preempted.

The divergent opinions in these cases have continued to create substantial confusion in the lower federal and state courts. A prime example of the havoc caused by these conflicting decisions is the case of *Isaac v. Life Investors Ins. Co. of America*, 749 F.Supp. 855 (E.D. Tenn. 1990). That case originated in a federal district court in the Eleventh Circuit and was transferred to a district court in the Sixth Circuit. In deciding whether plaintiff's fraud in the inducement claim was preempted, the district judge noted:

> *This Court is . . . left in a quandary.* On the one hand, the Eleventh Circuit, from whence this case arrived, has clearly and explicitly ruled that the plaintiffs' state law causes of action are preempted by ERISA . . . On the other hand, the Sixth Circuit, where the case is presently pending, has set forth what appear to be conflicting opinions . . . .

Id. at 855 (emphasis added). This is certainly not what Congress envisioned when it attempted to establish uniformity in the regulation of employee benefit plans.

The confusion over whether state law fraud in the inducement claims are preempted by ERISA is also long-standing, widespread, and continues unabated to the present day. *See, e.g., Macomber v. Digital Equipment Corp.*, 865 F.Supp. 65 (D. N.H. 1994) (noting a split in the circuits as to whether fraud in the inducement is preempted and siding with *Farlow*); *Adorno v. Nitzkin*, 828 F.Supp. 42 (N.D. Ill. 1993) (relying on *Perkins* to hold that a state law misrepresentation claim was not preempted where the conduct caused the plaintiff to cancel an existing policy and purchase a replacement policy); *Dipietro-Kay Corp. v. Interactive Benefits Corp.*, 825 F.Supp. 459 (D. Conn. 1993) (noting split in circuits regarding preemption of state law fraud in the inducement claims); *Smith v. Cohen Benefit Group, Inc.*, 851 F.Supp. 210 (N.D. N.C. 1993) (relying on *Perkins* to hold that state law claim based on pre-plan representation that preexisting condition would be covered is not preempted); *Kopozynski v. Central States Pension Fund*, 782 F.Supp. 350 (E.D. Mich. 1992) (noting confusion in circuit court decisions over whether state law fraud in the inducement claims are preempted by ERISA); *Bryant v. Blue Cross and Blue Shield of Alabama*, 751 F.Supp. 968 (N.D. Ala. 1990) (noting "sharp disagreement" between

Farlow and *HealthAmerica* and stating that disagreement "cannot be reconciled except by the Supreme Court of the United States"); *MNVA Railroad, Inc. v. John Alden Life Ins. Co.*, 507 N.W.2d 15 (Minn. App. 1993) (noting split in circuits and holding that fraud in the inducement claims are not preempted); *Kurtz, Richards, Wilson & Co., Inc. v. Insurance Communications Marketing Corp.*, 12 Cal.App.4th 1249, 16 Cal.Rptr.2d 259 (1993) (noting split in federal circuit courts and following *Perkins* to hold that fraud in the inducement claim against agent is not preempted); *Dearth v. Great Republic Life Ins. Co.*, 9 Cal.App.4th 1256, 12 Cal.Rptr.2d 78 (1992) (noting split in circuits and following *Farlow* to hold that fraud in the inducement claim against agent is preempted).

The confusion illustrated by these lower court decisions is the result of the significant disagreement among the federal circuit courts as to whether fraud in the inducement claims are preempted by ERISA. This confusion and conflict has now continued for several years and has spread to courts nationwide with literally no hope of resolution absent clarification by this Court.

F. This Case Involves Several Important Questions of Federal Law Concerning ERISA.

This Court has repeatedly acknowledged the importance of issues arising under the Employee Retirement Income Security Act, 29 U.S.C. §1001, *et seq.* ("ERISA") with regard to: (1) preemption of state law; (2) the exclusivity of ERISA's civil enforcement scheme; and (3) the uniform regulation of employee benefit plans. *See, e.g., Ingersoll-Rand Company v. McClendon*, 498 U.S. 133 (1990); *FMC Corporation v. Holliday*, 498 U.S. 52

(1990); *Mackey v. Lanier Collections Agency & Service, Inc.*, 486 U.S. 825 (1988); *Ft. Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983).

State law fraud in the inducement claims and the confusion over whether such claims are preempted by ERISA involve several crucial areas of ERISA preemption analysis, including:

- whether representations which occur prior to the purchase of a group insurance policy "relate to" the plan;
- whether claims which arise from representations by alleged agents of the plan insurer are preempted by ERISA; and
- whether an alternative ERISA remedy is a prerequisite for preemption of state law claims.

The Fifth Circuit erroneously permitted the plaintiffs to pursue a state law claim which clearly "relates to" the employee benefit plan at issue and thereby circumvent ERISA's exclusive civil enforcement scheme.

The Fifth Circuit decision is one of many in a long line of decisions causing confusion and conflict in the lower state and federal courts regarding application of the "relates to" test, particularly as it applies to state law fraud in the inducement claims. This confusion is causing ongoing frustration of Congressional intent that ERISA uniformly regulate employee benefit plans. Plan participants are bypassing ERISA's exclusive civil enforcement scheme by characterizing a claim arising out of the processing of plan benefits as a state law claim for "damages". In this sense, the confusion among the courts

is subjecting benefit plans to *de facto* oral modification because participants and beneficiaries are being allowed to pursue as state law "damages" the very benefits that were denied them under the terms of the plan. It is of paramount importance that this Court grant certiorari to resolve the nationwide conflicts over the preemption of state law fraud in the inducement claims.

CONCLUSION

For the foregoing reasons, the petition should be granted and this Court should issue a writ of certiorari to review the decision and judgment of the United States Court of Appeals for the Fifth Circuit.

Respectfully submitted,

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APPENDICES

APPENDIX A

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

REBECCA T. HUBBARD and JIM HUBBARD,

Plaintiffs-Appellants,

versus

BLUE CROSS & BLUE SHIELD ASSOCIATION, ET AL.,

Defendants,

BLUE CROSS & BLUE SHIELD ASSOCIATION,

Defendant-Appellee.

(92-2903 and 92-2908)

Appeal from the United States District Court
for the Southern District of Texas.

Before JONES and DeMOSS, Circuit Judges, and SCHWARTZ, District Judge.*

DeMOSS, Circuit Judge:

Plaintiff Rebecca Hubbard[1] was a beneficiary under a group insurance policy regulated by the Employee Retirement Income Security Act ("ERISA").[2] This appeal concerns whether Hubbard's state-law fraudulent inducement claims—brought against a third party other than the insurer—are preempted by ERISA. We hold that one of Hubbard's claims is preempted by ERISA and that the other claim is not preempted. We therefore AFFIRM the district court's entry of judgment in favor of the defen-

dant on one claim, and REMAND the other claim back to the district court.

BACKGROUND

Hubbard's employer, Texas A&M Research Foundation, provided an ERISA-regulated health benefits plan to its employees. Coverage was provided by Blue Cross and Blue Shield of Texas ("Blue Cross of Texas"), an entity not a party to this lawsuit. While Hubbard was a beneficiary under the health plan, she contracted cancer.[3] After Blue Cross of Texas refused to provide coverage for certain requested cancer treatments, Hubbard sued defendant-appellee Blue Cross and Blue Shield Association ("the Association") in the district court of Brazos County, Texas.[4] Hubbard claims that (1) the Association generated and disseminated secret policy interpretation "guidelines" which were followed by Blue Cross of Texas in denying coverage for Hubbard's treatment, and that the Association willfully concealed such guidelines from Hubbard, thereby fraudulently inducing her to participate in the Blue Cross of Texas plan rather than procuring other, adequate, health coverage; and (2) the Association disseminated advertisements in Texas that portrayed Blue Cross of Texas "as an honest and forthright company that would never engage in deceptive trade practices," thus fraudulently inducing her into participating in the "unsuitable" Blue Cross of Texas plan. Hubbard claimed that both acts by the Association were in violation of the Texas Deceptive Trade Practices Act, Tex. Bus. & Com. Code Ann. § 17.41 *et seq.*, and the Texas common law of fraud. Hubbard also alleged malpractice against her physician, Richard A. Smith of

Brazos County, Texas, claiming he negligently failed to diagnose the cancer.

The Association removed the case to federal district court, contending that Hubbard's state-law claims were completely preempted by ERISA.[5] The plaintiffs and defendant Smith moved to remand the case to Texas state court. After initially denying both motions, the court remanded the Hubbard's claims against Smith, but refused to remand their case against the Association.

On October 8, 1992, the district court granted summary judgment in favor of the Association on both of Hubbard's claims. The district court's four-page order concluded that all of the plaintiff's state-law fraudulent inducement claims were completely preempted by ERISA.[6] This appeal followed.

STANDARD OF REVIEW

We review a summary judgment de novo, under the same standard employed by the district court, affirming if there is no genuine issue of material fact and the movant is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *United Fire and Cas. Co. v. Reeder*, 9 F.3d 15, 16 (5th Cir. 1993); *Hibernia Nat. Bank v. Carner*, 997 F.2d 94, 97 (5th Cir. 1993).

ERISA PREEMPTION

The preemption clause in ERISA states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employer benefit plan." 29 U.S.C. § 1144(a) (expressly excepting two situations not applicable here). State law causes of action

such as Hubbard's are barred by § 1144(a) if (1) the state law claim addresses an area of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan; and (2) the claim directly affects the relationship between the traditional ERISA entities—the employer, the plan and its fiduciaries, and the participants and beneficiaries. *Weaver v. Employers Underwriters, Inc.*, 13 F.3d 172, 176 (5th Cir. 1994); *Memorial Hosp. System v. Northbrook Life Ins. Co.*, 904 F.2d 236, 245 (5th Cir. 1990). The language of the ERISA preemption clause is deliberately expansive, and has been construed broadly by federal courts. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1328-29 (5th Cir. 1992). A state cause of action relates to an employee benefit plan whenever it has "a connection with or reference to such a plan." *Id.* at 1329 (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983)).

Hubbard makes two basic claims of fraudulent inducement. She first alleges that the Association issued, and concealed, secret coverage guidelines ("the secret guidelines claim"). Her second claim alleged fraudulent inducement in connection with the Association's advertisements for Blue Cross of Texas ("the advertisement claim").[7] If neither claim is preempted by ERISA, then the district court lacks subject matter jurisdiction, because both claims arise under state law and there is no diversity of citizenship. If there is no federal jurisdiction, the case must be remanded to Texas state court.

However, we hold that Hubbard's claim involving the "secret guidelines" is preempted by ERISA, thus a federal question exists on that claim and the district court's exercise of jurisdiction was proper. Entry of summary judgment for the Association on that claim was also cor-

rect because ERISA provides no remedy. We hold that Hubbard's second claim, involving the Association's advertising, is not preempted by ERISA. We reverse the summary judgment as to the advertising claim and remand that part of the case so that the district court may exercise its discretion as to whether to accept supplemental jurisdiction pursuant to 28 U.S.C. § 1367 or remand the advertising claim to state court.

"SECRET GUIDELINES" CLAIM

Hubbard alleged that the Association "generated and disseminated to [Blue Cross of Texas] certain guidelines or criteria pertaining to how [Blue Cross of Texas] would interpret the terms 'experimental' and 'medically necessary.' "

> "[[Blue Cross of Texas] looked to and relied upon certain criteria and guidelines promulgated by [the Association] in order to make determinations concerning whether specific medical treatments were or were not excluded from coverage by the above-noted policy language . . . in effect, [the Association] added verbiage to the definitions of the aforementioned terms found in the insurance policy."

It is clear that ERISA preempts a state law cause of action brought by a plan beneficiary against the plan insurer alleging improper processing of a claim for plan benefits. *Memorial Hospital*, 904 F.2d at 245. We have also held that ERISA preempts state law claims of fraud, breach of contract or negligent misrepresentation that have the effect of orally modifying the express terms of an ERISA plan and increasing plan benefits for participants or beneficiaries who claim to have been misled. *Id.* at 245. Hubbard's "secret guideline" claim was brought

against a third party, the Association, rather than against the insurer. However, the essence of Hubbard's claim is that her benefits under the plan were improperly denied. Resolution of this claim would require an inquiry into (1) whether the Association generated and disseminated guidelines; (2) whether Blue Cross of Texas knew about those guidelines; (3) whether Blue Cross of Texas employed the alleged guidelines in Hubbard's case; and (4) whether the guidelines materially affected the determination of non-coverage in Hubbard's medical treatment. Such questions are intricately bound up with the interpretation and administration of an ERISA plan. Accordingly, we hold that the "secret guideline" claim relates to an employee benefit plan and is preempted by ERISA. *See Corcoran v. United Healthcare Inc.*, 965 F.2d 1321, 1334 (5th Cir.) (holding that ERISA preempted state law claims against a non-ERISA entity, the utility review administrator for its decision that affected a benefit determination under the ERISA plan). Because ERISA provides no remedy on these facts, the district court correctly granted summary judgment in favor of the Association in Hubbard's secret guideline fraudulent inducement claim.

ADVERTISING CLAIM

Hubbard also alleged that the Association "distributed advertisements designed to promote Blue Cross [of Texas] as an honest and forthright company that would never engage in deceptive trade practices." Hubbard claimed that she "relied upon the images created by such advertising and [was] thereby induced to acquire the services of Blue Cross [of Texas]." Hubbard claims that she was damaged by the advertising in that she relied on the

assurances of quality coverage and thus chose not to procure other insurance coverage to insure that the expensive medical treatments that she needed could be paid for.

Hubbard relies heavily on our holding in *Perkins v. Time Ins. Co.*, 898 F.2d 470, 473 (5th Cir. 1990), which also involved fraudulent inducement allegations against a third-party, non-ERISA entity. In *Perkins*, the plaintiff claimed that an insurance agent fraudulently induced him to surrender his previous insurance coverage and elect to participate in a new ERISA plan. The agent falsely assured the plaintiff that the new policy would cover his daughter's impending treatment for congenital eye defects. In fact, the treatment was not covered under the policy because the eye problem was an excluded preexisting condition. *Perkins*, 898 F.2d at 472. We held that, although the claim against the insurer, Time Insurance, was preempted by ERISA, the claim against the insurance agent was not preempted.

> "While ERISA clearly preempts Perkins' claims as they relate to Time, the same cannot be necessarily said, however, as regards [the insurance agent]'s solicitation of Perkins, which allegedly induced him to forfeit an insurance policy that covered his daughter's condition for one that did not. While ERISA clearly preempts claims of bad faith as against insurance companies for improper processing of a claim for benefits under an employee benefit plan, and while ERISA plans cannot be modified by oral representations, we are not persuaded that his logic should extend to immunize agents from personal liability for their solicitation of potential participants in an ERISA plan prior to its formation."

Perkins, 898 F.2d at 473. Thus, *Perkins* held that a state law fraudulent inducement claim against a third party other than an ERISA entity is not preempted by ERISA if it does not implicate the plan's administration of benefits of "affect the relations among the principal ERISA entities (the employer, the plan fiduciaries, the plan and the beneficiaries)." *Id.* We reaffirmed the *Perkins* rationale in *Memorial Hospital*, 904 F.2d at 247, where we stated that courts are less likely to find preemption when the claim merely affects relations between an ERISA entity and an outside party, rather than between two ERISA entities. *Memorial Hospital*, 904 F.2d at 249 (citing *Perkins*, 898 F.2d at 473; *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.*, 793 F.2d 1456, 1467 (5th Cir. 1986), *cert. denied*, 479 U.S. 1034 (1987).). Therefore, we hold that Hubbard's advertising claim is not preempted by ERISA.

In light of this holding, we remand the advertising claim to the district court so that the court can exercise its discretion either to (1) accept supplemental jurisdiction over the state law claim or (2) decline jurisdiction and remand the claim to state court. A federal district court may entertain state law claims pursuant to its "supplemental jurisdiction," provided that the claims arise from the case or controversy over which the district court had original jurisdiction. *See* 28 U.S.C. § 1367; *Welch v. Thompson*, 20 F.3d 636, 644 (5th Cir. 1994). When all federal claims are dismissed, the district court enjoys wide discretion in determining whether to retain jurisdiction over the remaining state law claims. *Welch*, 20 F.3d at 644; *Burns-Toole v. Byrne*, 11 F.3d 1270, 1276 (5th Cir. 1994) (both upholding district court's refusal to exercise jurisdiction); *see also Rodriguez v. Pacificare of*

Texas, Inc., 980 F.2d 1014, 1017-18 & n.3 (5th Cir. 1993) (upholding district court's exercise of supplemental jurisdiction over non-preempted state law claims when other state law claims by plaintiff were preempted by ERISA).

CONCLUSION

Therefore, for the reasons stated in this opinion, we hold that Hubbard's secret guideline claim is preempted by ERISA, and that her claim alleging fraud in the Association's advertising was not preempted. We therefore AFFIRM the district court's entry of judgment in favor of the defendant on the secret guideline claim, and REMAND the advertising claim back to the district court so that the court can exercise its discretion as to whether to accept jurisdiction or remand to state court.[8]

AFFIRMED in part, REVERSED and REMANDED in part.

FOOTNOTES

* District Judge for the Eastern District of Louisiana, sitting by designation.

[1] The original plaintiffs were Rebecca Hubbard and her husband, Jim Hubbard. For convenience this opinion uses the designation "Hubbard."

[2] 29 U.S.C. § 1001 *et seq.* (West 1985 & Supp. 1994).

[3] This was the second time Mrs. Hubbard had contracted cancer. She had a bout with breast cancer in the early 1980s, but that cancer had been pronounced cured well before she entered into the Blue Cross of Texas plan.

[4] The insurer, Blue Cross of Texas, and the defendant-appellee, Blue Cross and Blue Shield Association, are separate legal entities despite their similar names. The Association is incorporated in Illinois and is the trademark corporation that administers the licensing of the "Blue Cross" and "Blue Shield" registered trademarks. The Association did not issue the Hubbards' insurance policy and did not have the right or power to make coverage decisions under that policy.

The insurer, a Texas corporation, was never a party to this lawsuit. Hubbard settled her coverage dispute with Blue Cross of Texas in a separate action. That settlement provided for a payment of $12,500 to be divided among Hubbard, her minor children and her attorney. *Blue Cross & Blue Shield of Texas, Inc. v. Hubbard*, Civ. No. 3-91CV2651-R (N.D. Tex. May 4, 1993) (final judgment approving settlement agreement).

[5] Ordinarily, preemption of state law by federal law is a defense to a plaintiff's state law claim, and therefore cannot support federal removal jurisdiction under the "well-pleaded complaint" rule. "Complete preemption," in contrast, exists when the federal law occupies an entire field, rendering any claim a plaintiff may raise necessarily federal in character. *See Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1, 24 (1983). Because ERISA preemption is so comprehensive, it can provide a sufficient basis for removal to federal court even though it is raised as a defense, notwithstanding the "well-pleaded complaint" rule. *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987).

[6] The district court also stated an alternate basis for its judgment, finding that "Plaintiffs have failed to set forth in their first amended complaint a factual basis for their state claims."

[7] According to Hubbard's petition, both of these courses of conduct by the Association are actionable under the Texas DTPA, the Texas Insurance Code and the Texas common law of fraud.

[8] "We expressly do not rule on the sufficiency of the pleading of Hubbard's state law claims in this opinion since that issue is not ripe for determination until the district court rules regarding pendent jurisdiction."

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

REBECCA HUBBARD, et al.,	§	
	§	
Plaintiffs	§	
	§	
vs.	§	CIVIL ACTION NO. H-92-1294
	§	
BLUE CROSS AND BLUE SHIELD ASSOCIATION, et al.,	§	
	§	
	§	
Defendants.	§	

ORDER

Pending before the Court are Plaintiffs' and Defendant Richard A. Smith's motions to remand this case to state court. For the reasons below the Court finds the parties' motions to remand should be denied.

In their state court petition, Plaintiffs Jim and Rebecca Hubbard seek damages against Defendants Blue Cross and Blue Shield Association and Dr. Richard A. Smith. Plaintiffs allege that Ms. Hubbard's employer, Texas A & M Research Foundation, entered into a contract with Blue Cross and Blue Shield of Texas, Inc. to provide insurance coverage to employees, including Ms. Hubbard. Defendant Blue Cross and Blue Shield Association ("the Association") provided guidelines relating to how the insurer should interpret certain policy terms including "experimental" and "medically necessary." Plaintiffs allege that Defendant failed to disclose these definitions to

Plaintiffs and willfully concealed the definitions in order to induce Plaintiffs to apply for the policy.

In their state court petition, Plaintiffs allege that Blue Cross and Blue Shield of Texas denied coverage for certain cancer treatments in reliance on policies created by Defendant. Plaintiffs allege Defendant's false, misleading, and deceptive conduct violated the DTPA. Plaintiffs also allege Defendant took advantage of Plaintiffs' lack of knowledge concerning the policy to a grossly unfair degree in violation of the DTPA. Plaintiffs' alleged damages include "expenses for medical care and attention, physicians' fees, medical supplies, medicine and hospitalization."

In addition, Plaintiffs seek damages against Dr. Richard A. Smith. According to Plaintiffs, Smith failed to conduct any objective tests before attempting to diagnose her illness. Plaintiffs allege Dr. Smith violated his duty to exercise ordinary care and diligence and was negligent in his course of treatment.

On April 27, 1992, the Association filed a notice of removal of this lawsuit to federal court on the grounds that Plaintiffs' state law claims are preempted by the Employee Retirement Income Security Act of 1974 ("ERISA").

In their motions to remand, Plaintiffs and Smith argue removal was improper because ERISA does not preempt Plaintiffs' state law claims. According to Plaintiffs, the essence of their allegations is that the Association knowingly undertook a course of conduct designed to induce Plaintiffs to acquire insurance from Blue Cross of Texas. Plaintiffs argue that this allegation does not sufficiently "relate to" the plan, as is required for preemption. In

addition, Plaintiffs contend that they do not seek benefits under the policy nor do they seek to modify the benefits available under the plan. Finally, because the Association did not issue the policy at hand and did not have authority to make coverage decisions, Plaintiffs argue their claims are not preempted.

After reviewing the parties' arguments and the relevant caselaw, the Court finds that Plaintiffs' state law claims are governed by ERISA. Plaintiffs' allegations are based on the denial of coverage for medical treatment. *See Christopher v. Mobil Oil Corp.*, 950 F.2d 1209 (5th Cir. 1992), *petition for cert. filed May 26, 1992*. Alleging that a third party, rather than the plan itself, caused this denial does not change the nature of the claim. Further, Plaintiffs seek "expenses for medical care and attention, physicians' fees, medical supplies, medicine and hospitalization" as damages. In other words, Plaintiffs seek those expenses that would have been covered by the plan but for the alleged conduct of Defendant. *See Lee v. E.I. DuPont de Nemours and Co.*, 894 F.2d 755 (5th Cir. 1990), *petition for cert. filed*. For these reasons, the Court finds Defendants' removal of this lawsuit was proper. The Court therefore

ORDERS that Plaintiffs' motion to remand (entry #9) is DENIED. The Court further

ORDERS that Defendant Richard A. Smith's motion to remand (entry #8) is DENIED.

Signed this 27th day of July, 1992 at Houston, Texas.

/s/ Norman W. Black
NORMAN W. BLACK
UNITED STATES DISTRICT JUDGE

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

REBECCA HUBBARD, et al.,	§	
	§	
Plaintiffs	§	
	§	
vs.	§	CIVIL ACTION NO. H-92-1294
	§	
BLUE CROSS AND BLUE SHIELD ASSOCIATION, et al.,	§	
	§	
	§	
Defendants.	§	

ORDER

Pending before the Court is a motion for rehearing of Plaintiffs' motion to remand. Plaintiffs request that the Court reconsider their motion in view of Plaintiffs' first amended original petition.

After careful review of Plaintiffs' amended pleading, the Court finds no reason to change its ruling dated July 27, 1992 with regard to Plaintiffs' state law claims against Blue Cross and Blue Shield Association. Because these claims are sufficiently related to an employee welfare benefit plan, Plaintiffs' allegations are preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"). The Court therefore

ORDERS that Plaintiffs' motion to reconsider (entry #16) is DENIED concerning Plaintiffs' state law claims against the Association. The Court further

ORDERS that Plaintiffs' motion to reconsider is GRANTED with regard to Plaintiffs' allegations against

Dr. Richard A. Smith. Because Plaintiffs' allegations against Dr. Smith constitute separate and distinct claims involving questions of state law, the Court hereby

ORDERS that Plaintiffs' claims against Dr. Smith are REMANDED to the 85th Judicial Court of Brazos County, Texas.

Signed this 3rd day of September, 1992 at Houston, Texas.

/s/ Norman W. Black
NORMAN W. BLACK
UNITED STATES DISTRICT JUDGE

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

REBECCA HUBBARD, et al.,	§	
	§	
Plaintiffs	§	
	§	
vs.	§	CIVIL ACTION NO. H-92-1294
	§	
BLUE CROSS AND BLUE SHIELD ASSOCIATION, et al.,	§	
	§	
	§	
Defendants.	§	

ORDER

This case is before the Court on Defendant's motion to dismiss or for summary judgment. The Court has reviewed the pleadings and the applicable case law and finds that the motion should be granted.

Plaintiffs allege that Blue Cross & Blue Shield Association ("BCBS Association") had certain guidelines or criteria which it provided to Blue Cross & Blue Shield of Texas, Inc. ("BCBS of Texas") regarding how certain terms of an ERISA employee benefit plan should be interpreted. Plaintiffs also allege that BCBS failed to disclose these guidelines or criteria to them in order to induce them to apply for the ERISA plan policy, and that BCBS Association advertised that it was an honest company. Plaintiffs allege that this conduct constitutes a violation of the Texas Deceptive Trade Practices Act ("DTPA") and Article 21.21 of the Texas Insurance Code. Defendant has filed a motion for summary judgment,

asserting that these state claims are preempted by ERISA and must be dismissed and that Plaintiffs have failed to set forth a factual basis for their claims.

The Court has previously held in its denial of the motion to remand that Plaintiffs' state claims are sufficiently related to an employee welfare benefit plan and, therefore, are preempted by ERISA. *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Christopher v. Mobil Oil Corp.*, 950 F.2d 1209 (5th Cir. 1992) (state law preempted if claims have connection or reference to an employee benefit plan). Notwithstanding Plaintiffs' transparent attempt to characterize their claim in a manner to avoid application of ERISA, it is clear that resolution of their state claims would "have the *effect* of orally modifying the express terms of an ERISA plan and increasing plan benefits for participants or beneficiaries who claim to have been misled." *Memorial Hospital System v. Northbrook Life Insurance Co.*, 904 F.2d 236, 245 (5th Cir. 1990) (emphasis added). The essence of Plaintiffs' claims is that their benefits under the plan were improperly denied, albeit through the alleged fault of BCBS Association. Plaintiffs' claims could not exist but for the ERISA plan, and the claims are related to their rights as participants to benefits under the plan. Because the claims "address areas of exclusive federal concern" and "affect the relationship among traditional ERISA entities," they are properly preempted by ERISA. *Id.*

Plaintiffs cite *Perkins v. Time Insurance Co.*, 898 F.2d 470 (5th Cir. 1990) in support of their argument that ERISA preemption does not apply. The Court finds *Perkins* to be factually distinguishable. In *Perkins*, an insurance agent contacted a business owner and solicited the participation of his business in a group insurance plan

offered by Time Insurance Company. The business owner specifically asked the agent whether treatment for a medical condition suffered by the owner's daughter would be covered in the proposed plan. The agent assured him that it would be covered and, based upon this affirmative representation of the agent, the employer/owner surrendered the coverage under an existing policy and enrolled the business in the plan proposed by the defendant agent. The court in *Perkins* held that such affirmative conduct by the agent in fraudulently inducing the employer to contract for the proposed plan would not be preempted. In the case at bar, however, there is no evidence of affirmative conduct by BCBS Association which induced, fraudulently or otherwise, Plaintiff's employer to select BCBS of Texas's policy for its ERISA health care plan.

In accordance with the discussion herein and the prior rulings of the Court, Plaintiffs' state claims are preempted by ERISA and Defendant's motion for summary judgment should be granted on that basis.

Additionally, the Court finds that Defendant's motion for summary judgment should be granted because Plaintiffs have failed to set forth in their first amended complaint a factual basis for their state claims. Specifically, Plaintiffs have failed to identify the "guidelines or criteria" or the advertising which form the basis for their amended complaint. Plaintiffs have failed to allege facts which would raise a duty on the part of BCBS Association to advise Plaintiffs of any such guidelines or criteria, for it is undisputed that no contractual or fiduciary relationship exists between Plaintiffs and BCBS Association. Plaintiffs have failed to allege facts which would support a finding of reliance by them on any BCBS Association

advertising, for the policy at issue was an employee benefit plan obtained through a contract of insurance between Plaintiff's employer and BCBS of Texas under which Plaintiffs were plan participants. Plaintiffs have also failed to allege facts which would support a finding that BCBS Association participated in the decision regarding coverage for Ms. Hubbard's medical treatment.

Based upon the foregoing, it is hereby

ORDERED that Defendant's motion to dismiss or for summary judgment (Entry #19) is GRANTED. A final order will be issued this day.

SIGNED this 8th day of October, 1992, at Houston, Texas.

/s/ Norman W. Black
NORMAN W. BLACK
CHIEF JUDGE
UNITED STATES DISTRICT

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

REBECCA HUBBARD, et al.,	§	
	§	
Plaintiffs	§	
	§	
vs.	§	CIVIL ACTION NO. H-92-1294
	§	
BLUE CROSS AND BLUE SHIELD ASSOCIATION, et al.,	§	
	§	
	§	
Defendants.	§	

FINAL ORDER

In accordance with the order issued this day, it is hereby

ORDERED that Defendant's motion to dismiss or for summary judgment (Entry #19) is GRANTED.

THIS IS A FINAL ORDER.

SIGNED this 8th day of October, 1992, at Houston, Texas.

/s/ Norman W. Black
NORMAN W. BLACK
CHIEF JUDGE
UNITED STATES DISTRICT

APPENDIX E

Excerpt from the Joint Appendix filed with the United States Supreme Court in *Pilot Life Ins. Co. v. Dedeaux*, No. 85-1043. [From Lexis GenFed/Briefs database, pp. 12-16.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF MISSISSIPPI THE SOUTHERN DIVISION

Civil Action No. S80-0467

EVERATE W. DEDEAUX, Plaintiff, versus PILOT LIFE INSURANCE COMPANY and ENTEX, INC., Defendants.

Jury Trial Requested

[Filed May 30, 1980]

COMPLAINT

TO THE HONORABLE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF MISSISSIPPI:

Comes now the plaintiff, Everate W. Dedeaux, and would show unto the Court the following facts, to-wit:

COUNT I

TORTIOUS BREACH OF CONTRACT

I

That plaintiff is an adult resident citizen of the State of Mississippi, residing at Rt. 1, Box 369, Saucier, Mississippi.

That at all times herein mentioned, defendant, PILOT LIFE INSURANCE COMPANY, is a foreign corporation

authorized to do business in the State of Mississippi, and that the registered agent for service of process is the Commissioner of Insurance for the State of Mississippi.

That at all times herein mentioned, defendant, ENTEX, INC., is a foreign corporation authorized to do business in the State of Mississippi, and that the registered agent for service of process is C T Corporation System, 118 N. Congress Street, Jackson, Mississippi 39205.

II

That at all times herein mentioned, defendants, and each of them, were the agents and employees of the other defendant, and were at all times acting within the purpose and scope of said agency and employment, and each defendant has ratified and approved the acts of his agent.

III

That prior to March, 1975, defendant, PILOT LIFE INSURANCE COMPANY, issued a group disability insurance policy to Entex, Inc., which provided disability benefits to the employees of Entex, Inc., being policy no. 7920 K. A copy of said written policy is in the possession of the defendants. Said insurance policy was entered into by plaintiff within the jurisdiction of the above entitled Court and required the payment of benefits within the jurisdiction of the above entitled Court in the amount of $463.63 per month for total disability.

IV

That plaintiff by and through his employer, Entex, Inc., has paid premiums due under said insurance policy to PILOT LIFE INSURANCE COMPANY at all relevant

times herein and further, plaintiff has performed all obligations under said policy on plaintiff's part.

V

That on or about March 26, 1975, plaintiff was seriously injured, which injury has caused plaintiff serious, permanent and total disability, which disability has continued to the present time. Plaintiff was required to leave work due to his disability on March 26, 1975, and has not returned to work since that date.

VI

That plaintiff filed a claim for total disability benefits under said policy due to a total disability from said injury.

VII

That defendants, and each of them, have breached their duty of fair dealing and good faith owed to plaintiff in the following respects:

A. Failure to make disability payments to plaintiff at a time when defendants knew plaintiff was totally disabled and entitled to said benefits under said insurance policy.

B. Failure to pay full amount of benefits due the plaintiff.

C. Willfully and in bad faith withholding or delaying payments from plaintiff knowing plaintiff's claim for total disability benefits under said insurance policy to be valid.

D. Terminating plaintiff's benefits at a time when defendants had insufficient medical information or other information within their possession to justify such action.

E. Terminating plaintiff's benefits for total disability without interviewing plaintiff or requesting an independent medical examination of plaintiff or obtaining other information bearing upon plaintiff's total disability status.

F. Refusal to honor the claim of the plaintiff without a legitimate or arguable reason.

G. Refusal to honor the claim of the plaintiff for reasons contrary to the express provisions of the policy.

H. Willfully and in bad faith using the fact of the unequal wealth and bargaining position of the parties to effect economic gain for the defendant.

I. By other acts or omissions of defendant.

VIII

As a proximate result of the aforementioned wrongful conduct of defendants, plaintiff has suffered damages under the terms of the insurance policy in the amount of $463.63 per month for a total amount to be shown at the time of trial.

IX

As a further proximate result of the aforementioned wrongful conduct of the defendants, plaintiff has suffered anxiety, worry, mental and emotional distress and other incidental damages, all to plaintiff's general damage in the sum of $250,000.00.

X

Defendants have willfully and intentionally wronged the plaintiff or have treated the plaintiff with such gross and reckless negligence as is equivalent to such a wrong,

entitling plaintiff to punitive damages in the sum of $500,000.00.

COUNT II

BREACH OF FIDUCIARY DUTIES

I

Plaintiff refers to each and every paragraph of the First Cause of Action and incorporates those paragraphs as though set forth in full in this cause of action.

II

By issuing said disability insurance policy to plaintiff and accepting premiums from him, defendants, PILOT LIFE INSURANCE COMPANY and ENTEX, INC., agreed and promised that if plaintiff became totally disabled, then the duty of defendants to pay benefits therefor would arise.

III

After plaintiff became totally disabled, he submitted a claim to defendants which gave rise to defendants' duty to pay benefits as herein alleged. After said duty to pay benefits arose, the sum of money attributable to said benefits was no longer the property of defendant, PILOT LIFE INSURANCE COMPANY, but was held by said defendant for the sole benefit and use of plaintiff, thereby creating a fiduciary relationship between defendant, PILOT LIFE INSURANCE COMPANY, and plaintiff.

IV

That defendants, and each of them, have breached their fiduciary duty to plaintiff by the acts or omissions set forth in the First Cause of Action, all to plaintiff's damage as set forth herein.

V

As a further proximate result of the aforementioned wrongful conduct of the defendants, plaintiff has suffered anxiety, worry, mental and emotional distress and other incidental damages, all to plaintiff's general damage in the sum of $250,000.00.

VI

That defendants, and each of them, have willfully and intentionally wronged the plaintiff or have treated the plaintiff with such gross and reckless negligence as is equivalent to such a wrong, entitling plaintiff to punitive damages in the sum of $500,000.00.

COUNT III

FRAUD IN THE INDUCEMENT

I

Plaintiff refers to each and every paragraph of the First Cause of Action and incorporates those paragraphs as though set forth in full in this cause of action.

II

That defendants, and each of them, made written and oral promises to plaintiff which were contained within the written and oral sales presentation made to plaintiff and within said insurance policy to pay plaintiff monthly disability benefits upon plaintiff becoming totally disabled and unable to work.

III

That defendants, and each of them, made said promises for the purpose of inducing plaintiff to rely upon said promises and to act in reliance upon them. Plaintiff re-

lied upon said promises and paid premiums in reliance thereon.

IV

That defendants did not intend to perform said promises to plaintiff and made said promises with intent to defraud plaintiff. Plaintiff was unaware of defendants' intention not to perform and justifiably relied upon the promises made by defendant.

V

As a proximate result of plaintiff's reliance upon defendants' promises and defendants' intention not to perform said promises, plaintiff sustained damages as alleged:

1. Damages for failure to provide benefits under the insurance policy in a sum to be determined at the time of trial.

2. General damages for mental and emotional distress and other incidental damages in the sum of $250,000.00.

3. Punitive and exemplary damages in the sum of $500,000.00.

Respectfully submitted,

EVERATE W. DEDEAUX

By: DENTON & PERSONS and ROBERTS, STELLY & ROSETTI

By: /s/ William L. Denton, of Counsel

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ROBERTS, STELLY & ROSETTI, Attorneys at Law, Post Office Drawer Y, Gulfport, Mississippi 39501, Telephone: (601) 863-4431, Attorneys for Plaintiff

APPENDIX F

ERISA, § 502(a), 29 U.S.C. § 1132(a)

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter of the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (B) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under subsection (c)(2) or (i) or (1) of this section.

APPENDIX G

ERISA, § 514(a), 29 U.S.C. § 1144(a)

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.